Determination of Reasonable Charges Under Part B of Medicare

A Training Workbook

Health Care Financing Administration
Medicare Bureau
MAB Pub. No. 029 (9-77)

The information presented in this booklet is not all inclusive and does not take the place of regulations, operating procedures, or manual instructions.

Medicare Bureau
Division of Management
Training and Career
Development Branch

Introduction

This workbook is intended for employees of the Health Care Financing Administration and other groups needing a basic understanding of the "reasonable charge" concept as applied to the payment of Medicare benefits. The reader is presumed to already possess a general knowledge of the Medicare program. For a more indepth discussion of reasonable charges, see "Determination of Reasonable Charges Under Part B of Medicare: A Basic Text," MAB Pub. No. 028.

This workbook is divided into three parts:

Part I - Preface and Programmed Learning Text

This part contains a brief narrative and a programmed learning text explaining "actual," "customary," and "prevailing" charges and their significance in the computation of "reasonable charges." The programmed learning text sets forth, in building-block fashion, the computation process and shows the relationship of this process to benefit payments to the beneficiary.

Part II - Examples and Exercises

This part contains a summary and several reinforcement exercises outlining the basic concepts of reasonable charge and relating these concepts to the day-to-day carrier operation.

Part III - Glossary of Terms

This part defines some of the terms most frequently used in discussing reasonable charges.

PART 1 - PREFACE AND

PROGRAMMED LEARNING TEXT

When considering the legislation which later became the Medicare law, Congress carefully studied methods of making payment for the services of physicians and other suppliers of medical services and supplies under Part B of the program. The decision was made that the "reasonable charge" method would best serve the needs of the people affected by the program.

The programmed learning text which follows should help you understand what is meant by the term "reasonable charges." This is a complex provision of the law, but by taking the steps one by one which go into making reasonable charge determinations, you should be able to understand the basic concepts.

Before proceeding to the programmed learning text, cut out the answer mask on the inside rear cover. Place the mask on the page so it reveals only the top frame, covering the answers at the right. After you have selected your response, slide the mask down to expose the correct answer and the next frame. Proceed in this manner.

Payment under Medicare for covered Part B services of physicians and other suppliers is usually made on the basis of "reasonable charges." READ ON	
The concept of paying for covered Part B services under Medicare on the basis of reasonable charges is found in the original Medicare Act. NO RESPONSE REQUIRED	
Generally, Medicare payment for covered Part B services is made on the basis of _____ _____.	reasonable charges
The determination of a reasonable charge involves three basic elements: 1. Actual charge, 2. Customary charge, and 3. Prevailing charge. PROCEED	
The Medicare carrier (a commercial insurance firm or Blue Shield Plan) responsible for processing the Part B claim makes the determination of the reasonable charge for a specific service based on these three elements. READ ON	

Blue Shield of Massachusetts, Inc., is the _____ that makes the reasonable charge determinations for covered Part B services rendered in its service area.	carrier
The Aetna Insurance Company in Washington is a Medicare carrier. This commercial insurance firm also makes _____ _____ determinations.	reasonable charge
These carriers also compute customary charges and prevailing charges so that the reasonable charge can be determined for a particular service. NO RESPONSE REQUIRED	
To understand reasonable charges, you must understand three basic elements. They are: 1. _____ _____; 2. _____ _____; 3. _____ _____.	1. actual charge 2. customary charge 3. prevailing charge
Before examining these concepts in detail, we will define a "reasonable charge" in general terms. A reasonable charge is the charge for a specific service which is the lowest of: 1. the actual charge billed for the service; 2. the customary charge of the physician or other supplier; 3. the prevailing charge in the locality. So, the reasonable charge determined for a service is the _____ of the actual, customary, and prevailing charges.	lowest

To place the reasonable charge concept into proper perspective, we will relate it to Medicare payment, complete with the concepts of deductible and coinsurance. The current Part B deductible is $60 per calendar year. Coinsurance is 20 percent of reasonable charges after the deductible has been met. GO ON TO NEXT FRAME	
Presently, the Part B deductible is satisfied when the beneficiary incurs $60 of reasonable charges for covered services in a calendar year. If Mrs. Baker submits $60 of this year's doctors' bills to the carrier and the reasonable charges for those bills are determined to be $60, her deductible _____ (has/has not) been met.	has
If Mr. Hunt submits $80 of doctors' bills in a calendar year and the carrier determines that the reasonable charges for those bills are $50, Mr. Hunt's deductible _____ (has/has not) been fully met.	has not
Medicare pays 80 percent of the reasonable charges after the deductible has been met. The remaining 20 percent is called coinsurance, for which the beneficiary is responsible. Any outstanding portion of the deductible will first be subtracted from the reasonable charge amount before the 80 percent payment and 20 percent coinsurance are calculated. NO RESPONSE REQUIRED	
1. To review briefly, Medicare pays for covered Part B services, generally, on the basis of a _____ _____ concept. 2. The reasonable charge is the lowest of the _____, _____, and _____ charges.	reasonable charge actual, customary, prevailing

Determinations of reasonable, customary, and prevailing charges are made by Medicare _____.	carriers
Now let's examine some of these elements a little closer. When a beneficiary receives a service from a physician, he will get a bill for services rendered. The amount billed for is the "actual" charge.	
READ ON	
The actual charge is the charge made by the physician or "other supplier" rendering the service. Dr. Kraus bills Mr. Moore $15 for an office visit. This $15 charge is the _____ charge for that service.	actual
"Other supplier" (referred to above) is the term we use for suppliers of covered Part B services other than physicians. Some examples are ambulance companies, suppliers of durable medical equipment (such as wheelchairs), and suppliers of prosthetic devices (such as artificial limbs). NO RESPONSE REQUIRED	
The Valley Ambulance Company bills Mr. Lewis, a Medicare beneficiary, $35 for an emergency trip to the hospital. The Ambulance Company in this case may be considered a _____ of a covered Part B service.	supplier

What is the actual charge submitted by the Valley Ambulance Company in this case? _____	$35
Now let us move on to a discussion of customary charges. A customary charge is the amount which best represents the actual charges billed for a particular service by a physician to his patients in general. (This definition also holds true for other suppliers of covered Part B services.) The term "best represents" means that if Dr. Anderson charged $15 for a service 80 times during a calendar year and $12 once for the same service, $15 would "best represent" the actual charges made to his patients in general for that service. READ ON	
The carrier, in order to make this determination of a physician's customary charge for a particular service, accumulates data on all the actual charges billed by that physician for that service during the preceding calendar year. If Dr. Kane has 100 actual charges for a particular service on the carrier's records, this information is used in computing Dr. Kane's _____ charge for that service.	customary
The actual charges by Dr. Kane accumulated by the carrier for appendectomies performed on Medicare beneficiaries throughout 1976 are the data used to determine his _____ _____ for appendectomies for fee screen year 1978 (July 1, 1977 - June 30, 1978). (Customary charges are computed at the beginning of the fee screen year based on actual charges in the preceding calendar year. We'll learn more about this later.)	customary charge
The carrier arranges the actual charge data in ascending order. Stated another way, the carrier "arrays" the data from the lowest charge to the highest charge. The words "arrange" and _____ mean essentially the same thing in this context.	"array"

Let's look at a simple example. If we array the following actual charges for a given service by a certain physician in ascending order, it would look like this: Actual Charges Not Arrayed: $6, 8, 6, 6, 7 Actual Charges Arrayed: $6, 6, 6, 7, 8 NO RESPONSE REQUIRED	
Array the following charges in ascending order: $25 ____ 28 ____ 28 ____ 27 ____ 24 ____	$24 25 27 28 28
It is this array of actual charge data that the carrier uses to compute the customary charge for a given service by a physician to his patients in general. Remember, it is the same for other suppliers of covered Part B services and supplies. GO ON TO NEXT FRAME	
How does the carrier determine which charge in the array "best represents" the actual charges? Simple. The carrier finds the median (midpoint) of the actual charge data. The _____ is the point on the array that determines the customary charge.	median
The median is the statistical term indicating the midpoint in an array of charge data. Stated another way, the median charge is the lowest charge below which at least 50 percent of the actual charges fall. Now let's proceed and look at some examples.	

Examples: A) $6, 6, 7 median, 7, 8 B) $145, 146, 148, 155, 160 median, 170, 180, 200, 210 At least _____ percent of the actual charges on an array fall below the median.	50
The median is the point in the above examples which determines the _____ charge for that service made by the particular physician.	customary
You may ask, "What is the customary charge when you have an even number of charges in the array?" Let's look at an example: Dr. Owens' actual charges for house calls in 1976 $10 11 11 11 ⟵ median ($11.50) 12 ⟵ customary charge ($12) 12 14 14 The median here is halfway between the $11 and $12 charge. As this is not an actual charge, the carrier selects the lowest charge which is high enough to include the median. Thus, $12 is the customary charge. GO ON TO NEXT FRAME	
We see now that, in order to make a determination of the customary charge for a given service by a physician, the actual charges for a calendar year must be arrayed in ascending order. Then the lowest actual charge which is high enough to include the _____ of this array is found to be the customary charge.	median

What is the customary charge in the following examples of actual charge data?

A)	B)	C)
$85	$350	$8 (4 times)
85	352	9 (6 times)
88	358	10 (5 times)
92	366	
94	370	
	375	
(ans)	(ans)	(ans)

A) $88

B) $366

C) $9

We made you "stretch" a little on example "C." Arrayed, the data would appear as follows:

$8
8
8
8
9
9
9
9 ←—— median (and the customary) charge
9
9
10
10
10
10
10

READ ON

Now let's summarize for a moment.

A customary charge is the amount which best represents the actual charges which were made for a given medical service by a particular physician to his patients in general.

The carrier _____ the actual charge data in ascending order to find the median.

arrays

The median, which statistically determines the customary charge, is the _____ of the array of actual charge data.

midpoint

To pull it together for you, when a carrier receives a Medicare claim for a covered Part B service rendered by a physician, it looks at the amount on the claim (the actual charge) and compares it against the customary charge established by the carrier for that physician, and the prevailing charge in that locality for the same service. The lowest of the actual charge, the customary charge, and the prevailing charge is then established as the reasonable charge for that service by that physician. NO RESPONSE REQUIRED	
We have not yet talked about the prevailing charge. This is the last element that must be discussed to round out the total concept of _____ _____.	reasonable charges
The prevailing charge is generally the lowest charge on an array of customary charges which is high enough to include 75 percent of all the customary charges. This is really not as complicated as it sounds. Let's go on and see how it works. READ ON	
The carrier determines the prevailing charge for a service in a locality by looking at all the customary charges made for that service by all the physicians in that locality. The prevailing charge is determined by the _____.	carrier
How does the carrier initially determine a prevailing charge? There are basically three steps involved in this process. They are: 1. "Weighting" the customary charges; 2. "Arraying" the weighted customary charges; and 3. Finding the 75th percentile of the array. NO RESPONSE REQUIRED	

In order to weight customary charges, the carrier records the number of times that a particular service was performed by a particular physician, keeping a cumulative total for all physicians in the locality. Each physician's customary charge is "weighted" when it is listed in the array the number of times that service was performed by the physician.

GO ON TO NEXT FRAME

Customary charges are _____ to provide the data used in determining the prevailing charge.

weighted

Let's look at some examples in the following frames.

EXAMPLE 1:

Dr. Abrams performs a certain service 25 times and the carrier calculates Dr. Abrams' customary charge for this service (using the process we previously described) to be $6.

Number of Times the Service Was Performed Regardless of the Amount Charged	Doctor	Customary Charge	Cumulative Total
25	Abrams	$6	25

The $6 customary charge should be listed 25 times in the prevailing charge array.

READ ON

EXAMPLE 2:

The carrier's records show that Dr. Brown, who practices in the same locality as Dr. Abrams, has performed the same service 50 times. Based on Dr. Brown's actual charges, his customary charge of $6 was calculated. The carrier's records will now show the following:

Number of Times the Service Was Performed Regardless of the Amount Charged	Doctor	Customary Charge	Cumulative Total
25	Abrams	$6	25
50	Brown	$6	75

READ ON

A physician's customary charge will be _____ by the number of times he provided the service, regardless of the amount he charged in each case.

weighted

Dr. Colby (also in the same locality) performed the same service 40 times. Based on his actual charge data, his customary charge for this service was determined by the carrier to be $7.

Complete the blanks in the next frame for Dr. Colby.

Number of Times the Service Was Performed Regardless of the Amount Charged	Doctor	Customary Charge	Cumulative Total	
25	Abrams	$6	25	
50	Brown	$6	75	
__	Colby	__	__	40, $7, 115

The "weighting" of Dr. Colby's customary charge is demonstrated by the indication that he performed this service _____ times.	40
The prevailing charge is initially determined by taking the 75th percentile of the array of "weighted" customary charges. The _____ percentile is used to determine the prevailing charge.	75th
The 75th percentile is found by reviewing the array of weighted customary charges, finding the number of charges in the array, and determining the point below which 75 percent of them fall. Let's review the example we have been building.	

Number of Times the Service Was Performed Regardless of the Amount Charged	Doctor	Customary Charge	Cumulative Total
25	Abrams	$6	25
50	Brown	$6	75
40	Colby	$7	115
35	Bean	$8	150
25	Elroy	$9	175

A. How many charges are included in this example? _____

A. 175

B. What is the lowest figure in the list of cumulative totals that includes at least 75 percent of all the charges? _____

B. 150
(175 x 75% = 131;
150 includes 131)

The customary charge falling within the answer to "B" is the 75th percentile of the array and is also the prevailing charge for this service in that locality. PROCEED	
What is the prevailing charge of the above example? _____	$8
In review then, the prevailing charge is initially determined by finding the _____ percentile of an array of _____ customary charges.	75th weighted
Before proceeding, you should know one additional fact. The actual charge data from which customary and prevailing charges are determined are collected during the calendar year (January 1 to December 31) preceding the start of the fee screen year. Customary and prevailing charges are revised at the beginning of each fee screen year. This process is called updating. READ ON	
Example: Data from calendar year 1976 (January 1, 1976 to December 31, 1976) are the basis for customary and prevailing charge determinations for fee screen year 1978 (July 1, 1977 to June 30, 1978). PLEASE CONTINUE	

The customary charge computed for a specific service for a particular physician is put into effect at the beginning of the fee screen year and is based on actual charge data collected on that physician during the preceding _____ _____ period.	calendar year
Dr. Hughes' customary charge for appendectomies, effective during fee screen year 1978, is based on his actual charges from _____ (date) to _____ (date).	1/1/76, 12/31/76
The prevailing charge for appendectomies for all physicians in a certain locality, effective at the beginning of the fee screen year, is based on the____ percentile of the weighted customary charges calculated from data collected during the _____ calendar year.	75th preceding
Have you noticed that we have been using the phrase "initially determined" with regard to prevailing charges? Well, you're right if you've guessed there's a bit more to come. READ ON	
In the case of physicians' services, there is another step in the determination of prevailing charges. This is the application of what is called the Economic Index. NO RESPONSE REQUIRED	

The Economic Index is a <u>limitation placed on increases in prevailing charges</u>. This Economic Index limitation pertains only to prevailing charges for Part B _____ services.	physicians'
To understand how the Economic Index affects determinations of prevailing charges, you should know something about the concept in general. PLEASE CONTINUE	
An "economic index," generally, is a measure of the price changes for an item or service in the economy from one time period to another. Medicare's Economic Index is based on increases since 1971 in the costs of physicians' office practices and in the earnings levels of workers in general.	
As a result of the Economic Index limitation, increases in _____ charges for physicians' services above fiscal year 1973 prevailing charges can be allowed only if they can be justified on the basis of economic changes. (Remember: Fiscal year 1973 prevailing charges are based on calendar year 1971 charge data.)	prevailing
Complicated? We agree! But don't give up. The concept will be clearer when we see <u>how</u> the Economic Index is applied to increases in prevailing charges. Medicare's Economic Index for fee screen year 1978 (beginning July 1, 1977) allowed prevailing charges for fee screen year 1978 to increase no more than 35.7 percent over fiscal year 1973 prevailing charges.	

This means that prevailing charges for physicians' services in fee screen year 1978 have been allowed to increase only _____ percent over those that were in effect in fiscal year 1973.

35.7

Remember now, Medicare's Economic Index applies only to _____ charges for _____ services.

prevailing, physicians'

Let's look at examples of a carrier's prevailing charges for two different physician services and how the application of the Economic Index effects them.

Service	FY 1973	Prevailing Charges Unadj. Fee Screen Year 1978	Adj. Fee Screen Year 1978
A	$100	$110	$110
B	$ 20	$ 30	$ 27.10 (rounded from $27.14)

(*Unadjusted prevailing charges are those based on customary charge data without any adjustment by the Economic Index.)

For service A, the carrier's unadjusted prevailing charge was within 35.7 percent of the fiscal year 1973 prevailing charge. However, for service B, the carrier had to reduce the amount allowable to the limit imposed by the Economic Index.

(35.7% of $20 = $7.14; $20 + $7.14 = $27.14--rounded to $27.10)

NO RESPONSE REQUIRED

Since you know how the Economic Index is applied, let's see you figure this one.

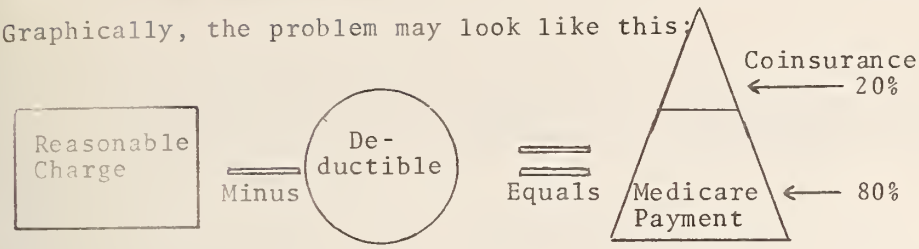
Service	FY 1973	Prevailing Charges Unadj. Fee Screen Year 1978	Adj. Fee Screen Year 1978
C	$100	$140	____

$135.70

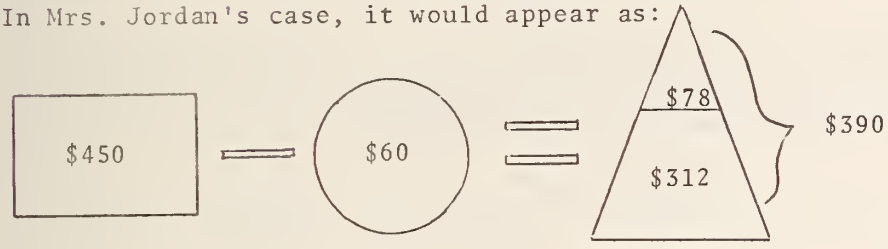
Here's one last comment before we leave the subject of Medicare's Economic Index. The examples we have given all relate to the Economic Index for fee screen year 1978 (which began July 1, 1977). In each succeeding fee screen year, new index figures are applied to reflect applicable changes in the economy. Assuming you are still with us, let's "regroup" and see where we stand.	
We have reviewed what the actual charge is and how customary and prevailing charges are determined. The reasonable charge for a specific service is determined on the basis of these concepts.	
READ ON	
The reasonable charge for a given service is the lowest of the: a. _____ _____; b. _____ _____; and c. _____ _____.	a. actual charge b. customary charge c. prevailing charge
The amount charged by a physician or "other supplier" for a specific service is the _____ charge.	actual
The Medicare carrier determines the _____, _____, and _____ charges from the actual charge data.	customary, prevailing, reasonable

If you answered "actual," "customary" and "prevailing" in the preceding frame, remember that an actual charge is not determined by the carrier. It is the charge submitted for a specific service by a particular physician or other supplier. READ ON	
Again, the reasonable charge is the lowest of the actual, customary, and prevailing charges. Assume the prevailing charge for a cystoscopy is $150. Dr. Benson bills a beneficiary $120 for a cystoscopy and the carrier (on the basis of Dr. Benson's charges in the past calendar year) determined Dr. Benson's customary charge to be $140. What is the reasonable charge for this service? _____	$120
The prevailing charge for procedure X is $100. Determine the reasonable charge in each of the following instances: 1. Dr. A bills Mr. Kelly $75 for procedure X even though Dr. A's customary charge is $80. The reasonable charge is _____. 2. Dr. B bills Mrs. Hall his customary charge of $125 for procedure X. The reasonable charge is _____.	1. $75 2. $100 (the lowest of the actual, customary, and prevailing charges)
Mrs. Jordan has met no part of her deductible for the calendar year. She becomes ill, requires surgery, and is billed $450 by Dr. Kline. She submits this bill to the carrier. The carrier reviews this actual charge and compares it to Dr. Kline's customary charge, determined for this service on the basis of Dr. Kline's actual charge data for the previous calendar year. The carrier then compares it to the prevailing charge for the same service rendered by all physicians in that same locality. 1. Assuming that the actual charge is determined to be the reasonable charge, what is the amount of the deductible Mrs. Jordan is responsible for? _____ 2. On what amount of the remaining reasonable charge will the carrier base its payment? _____ 3. How much will the carrier pay Mrs. Jordan? _____ 4. How much coinsurance will Mrs. Jordan pay? _____ NOTE: The beneficiary (Mrs. Jordan) is responsible for paying the doctor $60 (deductible) plus $78 (coinsurance)--a total of $138.	1. $60 2. $390 3. $312 ($390 X 80%=$312) 4. $78 ($390 X 20%=$78)

Graphically, the problem may look like this:

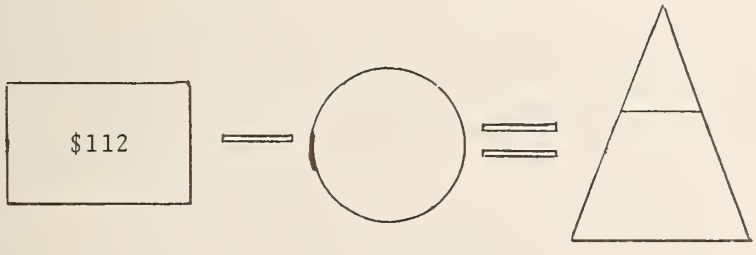


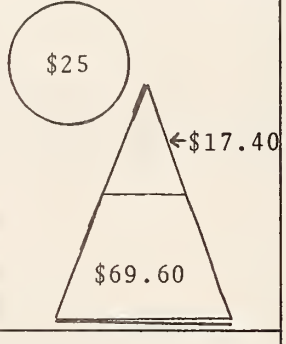
In Mrs. Jordan's case, it would appear as:



GO ON TO NEXT FRAME

Assume in the following problem that Mrs. Taylor has satisfied $35 of her deductible. She submits six more bills for covered office visits totaling $112. The reasonable charges for these services were determined to be $112. Complete the circle and triangle of our equation below.





Now let's summarize all we have learned about reasonable charges.

A "reasonable charge" is a charge for a specific service which is the lowest of:

1. the actual charge;
2. the customary charge; and
3. the prevailing charge.

Which of 1, 2, and 3 are computed by the carrier? _____

2 and 3

The actual charge is the charge made by the physician or other _____ of health services and supplies.	supplier
The customary charge is the amount which best _____ the actual charges made for a given medical service by a particular physician (or other supplier) to his patients in general.	represents
A physician's customary charge for a specific service is determined by finding the _____ of the physician's actual charges for that service arrayed in ascending order (i.e., from lowest to highest).	median (i.e., midpoint)
The prevailing charge is determined by finding the _____ percentile of an array of _____ customary charges of all physicians rendering the service in a locality.	75th weighted
Medicare pays _____ percent of the remaining reasonable charges after the deductible has been met. The beneficiary is responsible for the remaining _____ percent coinsurance.	80 20

One final note. If the physician submits the bill directly to the carrier for payment for services rendered to a beneficiary and agrees to accept the carrier's reasonable charge determination, he cannot then hold the beneficiary responsible for any difference between the reasonable charge and the actual amount billed. This is called the assignment method. (THE BENEFICIARY IS STILL RESPONSIBLE FOR ANY OF THE DEDUCTIBLE NOT YET MET, PLUS 20 PERCENT OF THE BALANCE OF THE "REASONABLE CHARGES" AND ANY CHARGES FOR SERVICES THAT MEDICARE DOES NOT COVER.) READ ON	
If Dr. Stein submits a charge for $10 directly to the carrier for services rendered to a beneficiary and agrees to accept Medicare's reasonable charge determination as his full charge, this is called the _____ method. If the carrier determines $7 of the amount to be the reasonable charge, how much will the carrier pay for this service (assuming the beneficiary's deductible has been met)? _____	assignment $5.60
How much is Dr. Stein allowed to bill the beneficiary, using this assignment method? _____	$1.40
In final summary, Medicare pays for covered Part B services of physicians and other suppliers, generally, on the basis of reasonable charges. A "reasonable charge" is a charge for a specific service which is the lowest of: --the actual charge for the service; --the physician's customary charge; and --the prevailing charge in the locality. Medicare pays 80 percent of reasonable charges after the annual $60 deductible has been met.	
END OF PROGRAMMED LEARNING TEXT.	

PART II - EXERCISES AND EXAMPLES

MAKING THE REASONABLE CHARGE DETERMINATION

We have said a lot about the customary charge of the individual physician or supplier and the prevailing charge of all physicians (or suppliers) for the same service in a locality. In short, we have discussed the reasonable charge for a service performed for a Medicare beneficiary.

Now, as an illustration of all that we have said so far, we will examine how a carrier applies this in establishing screens and making the reasonable charge determination.

In order to establish the customary charge profile for a physician and the prevailing charge screen for a procedure the carrier must collect data from claims being processed for Medicare and its own coverage. In our examination we will concentrate on Medicare data as there are too many variables in private health insurance coverage to permit a meaningful simplification at this time (see Comparability Provision).

The data collection process involves making a record of data on the claims from either the SSA-1490 or the itemized bill. This record is often called the history file. For reasonable charge purposes this data includes the physician identification, procedure identification, date of service, and the charge made. This information is captured from each Medicare claim in a calendar year. At the end of the year it is processed by the computer to provide the screens. Exhibit I shows a typical SSA-1490. Exhibit II illustrates how the data for reasonable charge purposes would look as an entry to a history file.

REQUEST FOR MEDICARE PAYMENT

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (See Instructions on Back—Type or Print Information)

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law

PART I—PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

Copy from YOUR OWN HEALTH INSURANCE CARD (See example on back)

1 Name of patient (First name, Middle initial, Last name)

2 Health insurance claim number (Include all letters) ☐ Male ☐ Female

3 Patient's mailing address — City, State, ZIP code — Telephone Number

4 Describe the illness or injury for which you received treatment (*Always fill in this item if your doctor does not complete Part II below*)

Was your illness or injury connected with your employment? ☐ Yes ☐ No

5 If any of your medical expenses will be or could be paid by another insurance organization or government agency (including FEHB, [illegible]) Name and address of organization or agency — Policy or Identification Number

Note: If you Do Not want information about this Medicare claim released to the above [illegible] ☐

6 I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the [illegible]

Signature of patient (*See instructions on reverse where patient is unable to sign*)

SIGN HERE

PART II—PHYSICIAN OR SUPPLIER

7 A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given — Procedure Code	Nature of illness or injury requiring services or supplies (if applicable)	Was related to accident	Leave Blank
7-4-70	0	office visit — 9004	carrier [illegible]		

8 Name and address of physician or supplier (*Number and street, city, State, ZIP code*)

Dr. A. Smith
7000 Security Blvd.
Boondocks, Pa.

{ carrier establishes locality from this

Total charges $

Physician or supplier code: 0951A

10 Amount paid $

11 Any unpaid balance due $

12 Assignment of patient's bill

☐ I accept assignment (See reverse) ☐ I do not accept assignment.

13 Show name and address of person or facility which furnished service (*if other than your own office or patient's home*)

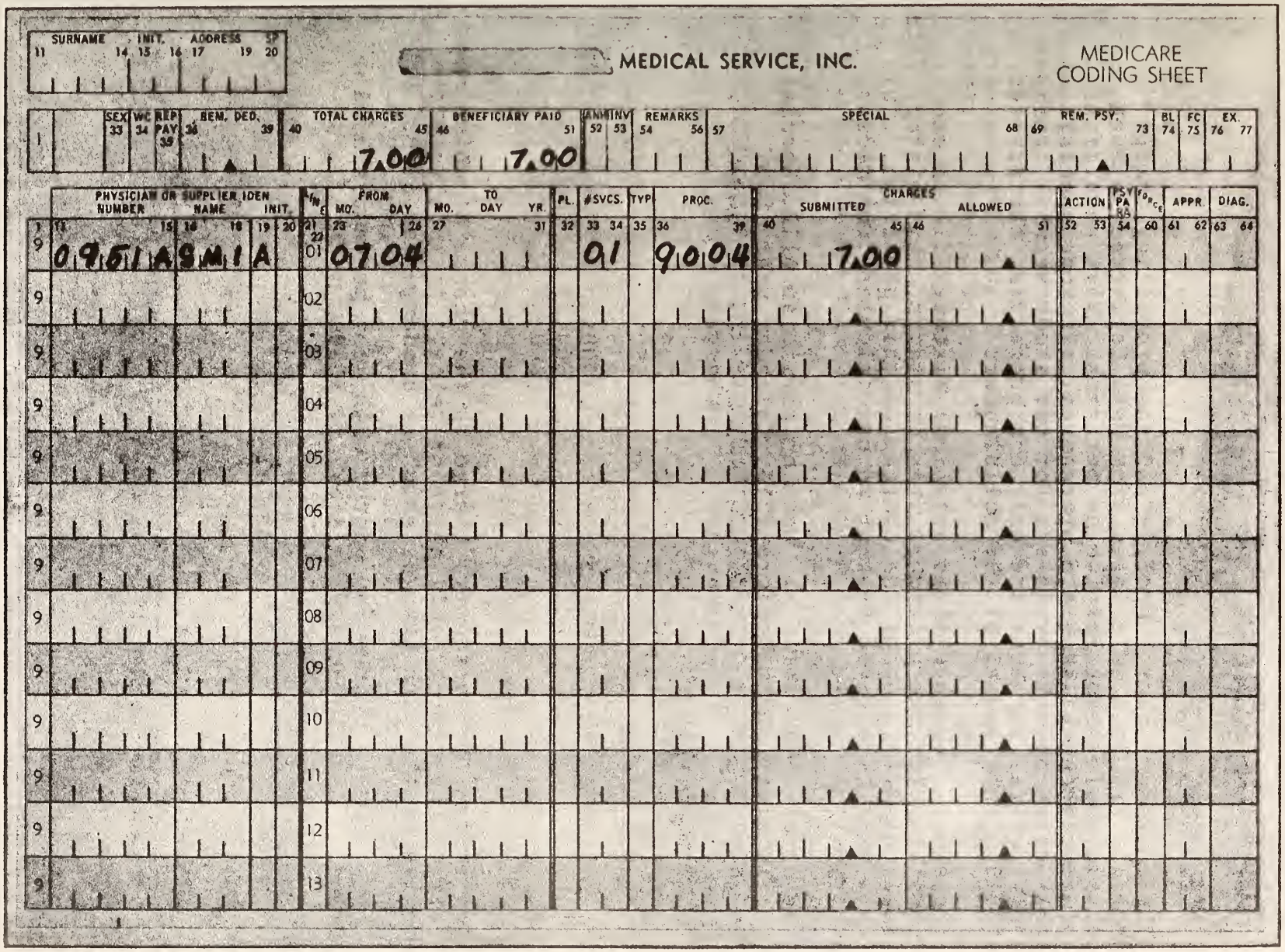
14 Signature of physician or supplier (*A physician's signature certifies that a physician's services were personally rendered by the physician or under the physician's personal direction*).

Date signed

*O—Doctor's Office
IL—Independent Laboratory
H—Patient's Home (*If portable X-ray services, identify the supplier*)
IH—Inpatient Hospital
SNF—Skilled Nursing Facility
OH—Outpatient Hospital
OL—Other Locations
NH—Nursing Home

FORM SSA 1490 (11-75)

Department of Health, Education, and Welfare
Social Security Administration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MEDICAL SERVICE, INC.
MEDICARE CODING SHEET
SEX 33
WC 34
REP PAY 35
REM. DED. 36 39
TOTAL CHARGES 40 45
7.00
BENEFICIARY PAID 46 51
7.00
ANN INV 52 53
REMARKS 54 56
SPECIAL 57 68
REM. PSY. 69 73
BL 74
FC 75
EX. 76 77
PHYSICIAN OR SUPPLIER IDEN NUMBER 10 15
NAME 16 18
INIT. 19 20
PIN 21 22
FROM MO. DAY 23 26
TO MO. DAY YR. 27 31
PL. 32
#SVCS. 33 34
TYP 35
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CHARGES SUBMITTED 40 45
ALLOWED 46 51
ACTION 52 53
PSY PA 54
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APPR 61 62
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1 9 0951 ASMI A 01 0704 01 9004 7.00
2 9 02
3 9 03
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CALCULATING THE CUSTOMARY CHARGES AND THE PREVAILING CHARGE SCREEN

The customary charge profile and the prevailing charge screens are both calculated from data collected on each physician for each service he performs. Most physicians provide about 25 separate procedures. In some specialties this could be more or less. For our study we will consider only general surgeons and only one procedure, cholecystectomy (3515), the removal of the gallbladder.

The exhibit on page 35 is a typical history file on one physician for one procedure. As it stands, this history file tells us little about the charges of this physician. This data must be arrayed so that we can calculate the median charge.

The array is as follows: Data on physician 611B, Specialty 02, locality, 03 procedure 3515, calendar year 1976.

Frequency	Charge
6	300
9	350
2	375
3	400
2	500
1	800
23	

The median (or customary) charge is the charge at which one half of the charges fall above or below. In this case the median is the 12th charge, which is a charge for $350.

The customary charge for doctor 611B, for procedure 3515 based on his 1976 charge history is $350.

Doctor Number 611B, Specialty 02, Locality 03

Date of Service	Frequency	Procedure Code	Charge
01-05-76	1	3515	500
01-15-76	1	3515	400
01-30-76	1	3515	350
02-05-76	1	3515	350
02-20-76	1	3515	350
02-28-76	1	3515	350
03-07-76	1	3515	300
03-28-76	1	3515	300
04-04-76	1	3515	300
04-20-76	1	3515	300
04-30-76	1	3515	300
05-10-76	1	3515	800
06-01-76	1	3515	500
06-15-76	1	3515	375
07-07-76	1	3515	375
07-24-76	1	3515	300
08-03-76	1	3515	350
08-18-76	1	3515	350
08-31-76	1	3515	350
09-02-76	1	3515	350
09-12-76	1	3515	350
09-30-76	1	3515	400
10-10-76	1	3515	400

This exhibit shows the accumulation of the data on the customary charges for all general surgeons in locality 3 who performed the procedure 3515 in the base year 1976.

Dr. ID #	Frequency	Median (Customary Charge)
611 B	23	350
604 C	8	450
356 D	10	500
039 E	17	400
002 F	4	450
004 G	5	450
053 H	2	500
088 I	3	500
011 J	5	500
019 K	2	400
316 L	1	425
358 O	1	500

Again this data must be arrayed and weighted to yield a prevailing charge for this procedure. The array would look like this:

Frequency	Customary Charge
23	350
19	400
1	425
17	450
21	500
81	

The 75th percentile of customary charges would be the 60.75 charge. This charge is a charge for $500. Therefore, the prevailing charge for procedure 3515 in locality 3 is $500.

HOW REASONABLE CHARGE IS EMPLOYED IN A DAILY OPERATION

In the day-to-day review of claims the carrier uses the profiles and screens in the following manner.

The claim is received, as in Exhibit I. Frequently, only a narrative description is provided such as routine follow-up office visit. A clerk then refers to a manual to identify the procedure code. In the example we have, the procedure code is 9004.

This data is then handled in one of two ways. The clerk may check the charge against reference books to determine the reasonable charge (called a manual operation) or the data may be fed to the computer which makes the reference to the screens and establishes the reasonable charge (called an automated operation).

In either system certain tolerances may be used to hold down the volume of claims receiving special review. That is, charges which exceed the customary or prevailing screens without explanation are automatically reduced and the lower of either the customary or prevailing charge is paid, except for cases where the actual charge exceeds the screen by more than a certain amount. These claims are referred to a special unit for development.

For example, a carrier may apply a tolerance of $1.00 in deciding whether a claim for a routine follow-up office visit should be referred for special review. If, in our example, Dr. Smith had simply shown routine office visits on his bill of $8 and his customary charge was established as $7, the reasonable charge of $7 would be established and benefit payment of $5.60 would be made (80 percent of $7). If, however, the claim showed "routine office visit $10" the claim would be set aside and the physician contacted to see if some other service was rendered, such as the administration of an injection.

Where the claim involved unusual circumstances or a complex surgical procedure, it would be forwarded immediately to either a special review group or the carrier's medical advisor. In this case the charge data would not be included in the data contained in the physician's history file.

PART 3

REINFORCEMENT EXERCISE

A. Using the history file in this example determine the customary charge for doctor 316 L for procedure 3101

DATE OF SERVICE	FREQUENCY	PROCEDURE CODE	CHARGE
01-03-76	1	3101	$300
01-08-76	1	3101	250
01-23-76	1	3101	300
02-14-76	1	3101	300
02-30-76	1	3101	400
03-07-76	1	3101	300
03-21-76	1	3101	350
03-28-76	1	3101	250
04-11-76	1	3101	250
04-24-76	1	3101	300
05-08-76	1	3101	450
05-20-76	1	3101	350
06-03-76	1	3101	500
06-15-76	1	3101	300
06-29-76	1	3101	300
07-17-76	1	3101	450
08-08-76	1	3101	575
08-24-76	1	3101	600
10-07-76	1	3101	350
10-31-76	1	3101	400
11-07-76	1	3101	300

B. Using the customary charge data below, determine the prevailing charge for procedure 3101.

FREQUENCY	CUSTOMARY CHARGE
4	$200
18	250
26	300
19	350
18	400
13	450
11	500
9	550
3	575
3	600

C. If doctor 316L bills the carrier $425 for procedure 3101 performed on HI Benny on August 5, 1976. how much benefit payment will he receive (assuming that Mr. Benny has not met any part of his deductible)?

REINFORCEMENT EXERCISE ANSWERS

A. $300. First, the customary charges must be arranged in ascending order:

250
250
250
300
300
300
300
300
300
300
300 - the median
350
350
350
400
400
450
450
500
575
600

The median is the 11th charge (total charges - 21) Therefore, working in an ascending order the 11th charge is $300.

B. $450. 124 X 3/4 - 93. Working in an ascending order, the 93rd charge is $450.

C. $192. The reasonable charge is $300. (lowest of actual, customary and prevailing charges) $60 is deducted to satisfy H.I. Benny's deductible.
$240 X 80% - $192.00

PART III - GLOSSARY OF TERMS

GLOSSARY OF TERMS

ACTUAL CHARGE A charge made by a physician or other supplier of Part B medical services, which is the basic data used in the determination of reasonable charges.

ARRAY The term describing an ordered arrangement of charge data in the carriers' files. For reasonable charge purposes it implies an ascending order of charges (i.e., the lowest amount at the top and the highest amount at the bottom).

ASSIGNMENT A method of Medicare payment in which the physician or other supplier of Part B services applies directly to the carrier for reimbursement (with the beneficiary's approval). It constitutes an agreement by the physician (or other supplier) that his total charge will not exceed the carrier's determination of the reasonable charge. The beneficiary is responsible only for any of the Part B annual deductible not yet met, plus 20 percent of the balance of the reasonable charge. The beneficiary cannot be billed for the difference between the submitted charge and the reasonable charge.

BASE YEAR AND CALENDAR YEAR Carriers develop revised customary and prevailing charge screens after the end of the calendar year, based upon all available charge data for services rendered during all of that calendar year (January 1 through December 31). They implement these screens at the beginning of the following fee screen year.

Example: The base year for rates effective with the beginning of fee screen year 1978 (7-1-77) is the calendar year 1-1-76 through 12-31-76.

CARRIER A commercial insurance firm or Blue Shield plan administering Part B of Medicare. It is distinguished from commercial insurance plans or Blue Cross plans administering Part A which are referred to as intermediaries.

CHARGE DATA The statistics on actual charges collected from submitted claims (and all other available sources) and used as the bases for the carriers' computations of the customary, prevailing, and reasonable charges.

COMPARABILITY PROVISION A provision of the Medicare Act specifying that the reasonable charge for a service may not be higher than the charges applicable for comparable services and under comparable circumstances to the carriers' own policy-holders and subscribers.

COINSURANCE A provision by which the insured person shares part of his own medical expenses. In reasonable charge discussions it refers to the 20 percent of reasonable charges for which the Medicare beneficiary is responsible after the Part B annual deductible has been met.

COVERED SERVICES The term used to describe the medical and other health services for which Medicare Part B payment can be made.

CUSTOMARY CHARGE The amount computed by the carrier based on actual charge data for a specific service performed by one physician (or other supplier) to his patients in general. It is a computation essential to the determination of the reasonable charge in a given claim.

DEDUCTIBLE The portion of reasonable charges (for covered services each calendar year) for which a beneficiary is responsible before his benefits begin. For Medicare, currently it refers to the first $60 of incurred expenses in a calendar year determined to be reasonable charges by the carrier.

DURABLE MEDICAL EQUIPMENT Equipment which can stand repeated use, is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of illness or injury.

ECONOMIC INDEX A cumulative figure representing changes in physicians' costs of practice and changes in general earnings levels which acts as a ceiling on increases in prevailing charges for physicians' services.

FEE SCREENS Another term describing the customary, prevailing and reasonable charge amounts established by the carrier at the beginning of each fee screen year. (July 1 of one year to June 31 of the next year.) It implies that charges (or fees) in excess of these computed rates are "screened out."

GENERAL PRACTITIONER A doctor of medicine who generally performs a wide range of medical services as opposed to one who specializes only in certain areas (see Specialist).

HISTORY FILE A listing of charges collected from submitted claims (SSA 1490's) on a specific physician or other supplier, arranged in ascending order, and used in the computation of the customary, prevailing and reasonable charges.

LOCALITY For the purpose of making reasonable charge determinations, a locality is identified as a geographic area for which a carrier derives the prevailing charges for services. Usually, a locality is a political or economic subdivision of a State which should include a cross-section of the population with respect to economic and other characteristics.

MEDIAN The statistical term indicating the midpoint in an array of charge data. The median charge is the lowest charge below which at least 50 percent of the actual charges fall.

"OTHER" SUPPLIERS The term used to describe non-physician suppliers of covered Part B medical services and supplies under Medicare. Examples: ambulance companies, drug stores dealing in wheelchairs, crutches, etc.

PERCENTILE The value in an array of data below which a given percentage of the items in the array fall. For example, in determining the prevailing charge for a service, carriers calculate the 75th percentile of the array of customary charges for the service (see Prevailing Charge).

PREVAILING CHARGE Generally, the lowest charge on an array of customary charges which is high enough to include 75 percent of all the customary charges.

PROFILE The term describing the carrier's record of calculated customary charges for each physician and supplier of Part B medical services.

PROSTHETIC DEVICE A device which replaces all or part of an internal body organ, or all or part of the function of a permanently inoperative or malfunctioning internal body organ. Examples: An artificial leg, cataract lenses, a cardiac pacemaker.

REASONABLE CHARGE An individual charge determination made by a carrier on a covered Part B medical service or supply. In the absence of unusual medical complications or circumstances it is the lowest of 1) the physician's or other person's customary charge for that service; 2) the prevailing charge for similar services in the locality; and 3) the actual charge of the physician or other person rendering the service.

RELATIVE VALUE STUDY (RVS) A method by which certain medical societies have identified the relative value of each procedure or service provided by physicians in relation to the values of other services. Where there is no reliable statistical basis for determining the customary charge of a physician or other person for a particular medical procedure or service, or for determining the prevailing charge, the carrier may develop or use an existing relative value study.

SPECIALIST A physician who works primarily in a certain area of medicine; e.g., neurosurgery, opthalmology, urology, internal medicine, general surgery. A specialist may be so designated because of board eligibility, board certification, or because of his own restriction of his practice to a certain specialty.

UNUSUAL CIRCUMSTANCES Medical complications or other circumstances requiring additional time, effort or expense to such an extent that the service is essentially different from the usual. These "unusual circumstances" may justify payment in excess of the established customary or prevailing charges for the more common service.

UPDATING A term describing the revision of customary, prevailing, and reasonable charge screens, using a new base year's charge data. It takes place at the beginning of each fiscal year, or as soon thereafter as the new screens can be incorporated into the carrier's claims processes.

WEIGHTING Recognizing the number of times each value occurs in a distribution. This permits each value to express its individual effect on a calculation. For example, in establishing the prevailing charge for a particular procedure, the carrier weights each calculated customary charge by how often the procedure was performed by that provider.

COMMENTS ON

REASONABLE CHARGES--A TRAINING WORKBOOK

As a user of this booklet, your opinion on the following is solicited:

1. In what way did you find the booklet useful?

2. How would you improve the booklet?

3. What Medicare-related topics would you suggest for similar publications?

4. What is your organization and position?

Address comments to:

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Division of Management
Training and Career Development Branch
Program Training Group
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Baltimore, Maryland 21235

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